Meaningful Use Stage One Implementation – a Local Perspective

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Meaningful Use Stage One

- Much of the work for stage one done at state level (except large cities)
  - Syndromic Surveillance message acceptance
  - Electronic Lab Reporting message acceptance
  - Immunization Registry participation
- Many LHDs working to collaborate more closely with state to ensure receive data they need from state built systems
  - A few states and localities have collaborative HIT committees where locals and states discuss coordination of systems and issues around implementation
  - Those who have no such collaborative report a disconnect between the overarching state plan and local systems, needs, and implementations

Meaningful Use Stage One

- At the local level, many LHDs pursued EHR technology and incentive payments
  - Some successful, but many have run into challenges
  - Major barriers
    - Billing (though stage 2 has zero paid billing)
    - Eligible providers (many have promised their incentives elsewhere)
    - Many of the "off the shelf" EHR solutions lack understanding of public health
  - Misunderstandings of why to have an EHR
    - Many felt had to have an EHR to plug into HIE
      - beginning to find something different
    - Some reporting found a need for practice management software instead
  - Some LHDs have come to the conclusion EHR not worth expense
    - Heavily dependent on level of clinical service provided

What are major challenges that LHDs face in implementing MU provisions?

- MU learning curve
- Time
- People
- Skilled workforce in informatics
  - Any one of the tasks before a local health department to accept one or more of the public health meaningful use measures, properly route the data, use the data in meaningful ways, and turn around appropriate bi-directional messages would stretch and overwhelm current capabilities. Doing all of these tasks along side of business as usual and major financial cuts is truly challenging.
  - However, it isn't all because of poor resources. Health departments have historically not been agile cohesive organizations – instead they have often been programmatic, siloed, and full of tradition. While this isn't all bad, they will have to re-think that business model in order to survive moving forward. Health departments should be thinking about ways to create efficiencies, be nimble, work across programs, and reach out to private sector partners.

What are unintended pluses of MU?

- Greater awareness of syndromic surveillance
- Pushing public health to rally around standards and more uniform best practices
  - Have made good progress in a shorter period of time
- Challenges remain
  - Defining standards is difficult work that takes lots of dedicated staff time
  - Many locals don't perceive having that time to give and often find the work too technical
  - Need more local involvement to ensure local needs are met

What key alignments between health care and PH are emerging because of MU?

- Potential key alignments exist, but have not yet been capitalized
  - ACOs and HIEs are in need of two categories of services
    - Care coordination/case management/home visits
      - ACOs and HIEs are working to develop in house resources rather than contracting with LHDs. One notable exception is the MN Beacon, where they have contracted with the local health department to provide these services and better integrate them into the care team. This has been quite successful and may be a good model for other areas.
    - Community/population assessment/analytics
      - HIXs/HIEs/ACOs have the data LHDs need. However they lack the perspective LHDs have. They have traditionally cared only about their population – not THE population. And they are scrambling to develop or contract for this analytic capability.
- Right now these are real opportunities for public health to partner with HIEs/ACOs. If we wait too long, other players could corner these markets and public health will stand to lose more core services

What are main benefits of MU to LHDs?

- MU gives LHDs a prominent place at the table
  - Enhance how the LHD is perceived and understood
    - Public health must assert itself
    - Public health must make clear the value it adds to the new healthcare paradigm
    - Need to decide what data we want, provide good reasoning for it, and work with our partners to receive it
- Stand to get more complete and better data
  - We must then ensure that we turn those data into meaningful information – this will help solidify our spot as a valuable partner in the new healthcare paradigm
- Main benefit is for public health to be a more integral part of the healthcare team

Questions?

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